

Conrail Freight Train Derailment with Vinyl Chloride Release

Paulsboro, New Jersey
November 30, 2012
Paul L. Stancil, Investigator-in-Charge

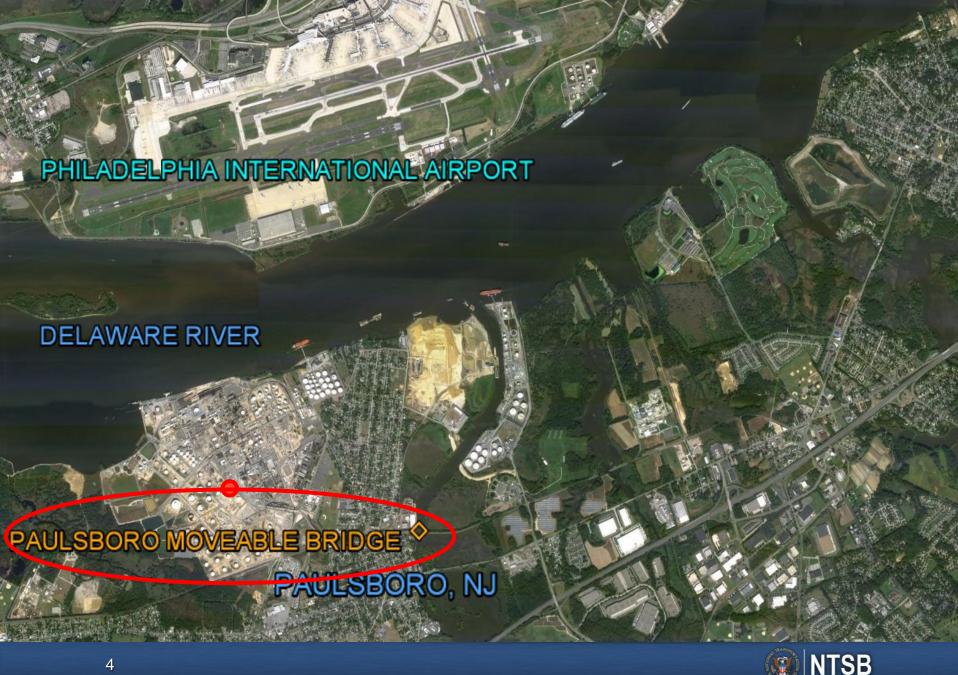




Injuries and Damages

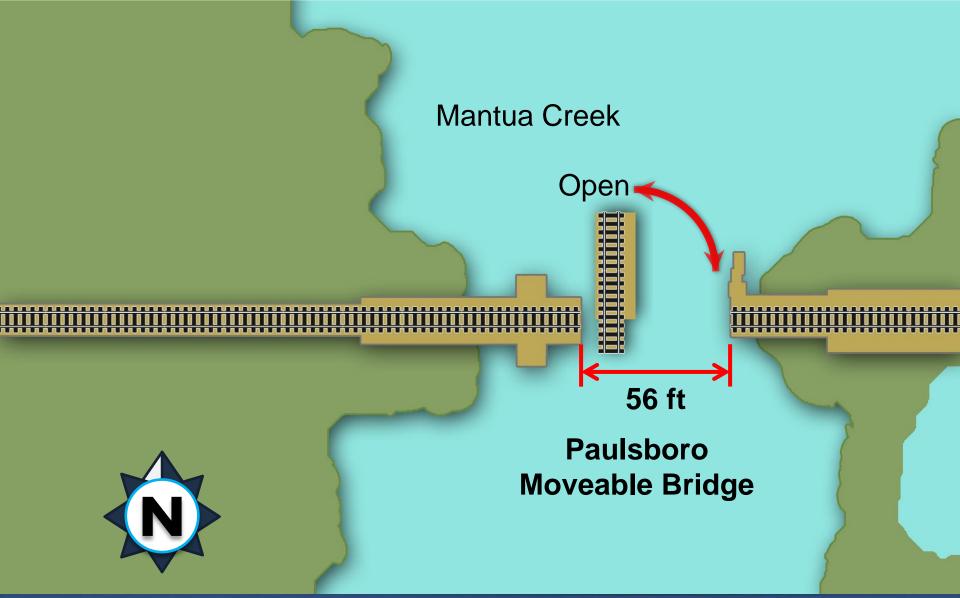
- Emergency responders and residents exposed to vinyl chloride
- 28 residents treated at hospitals
- \$451,000 equipment damage
- \$30 million emergency response





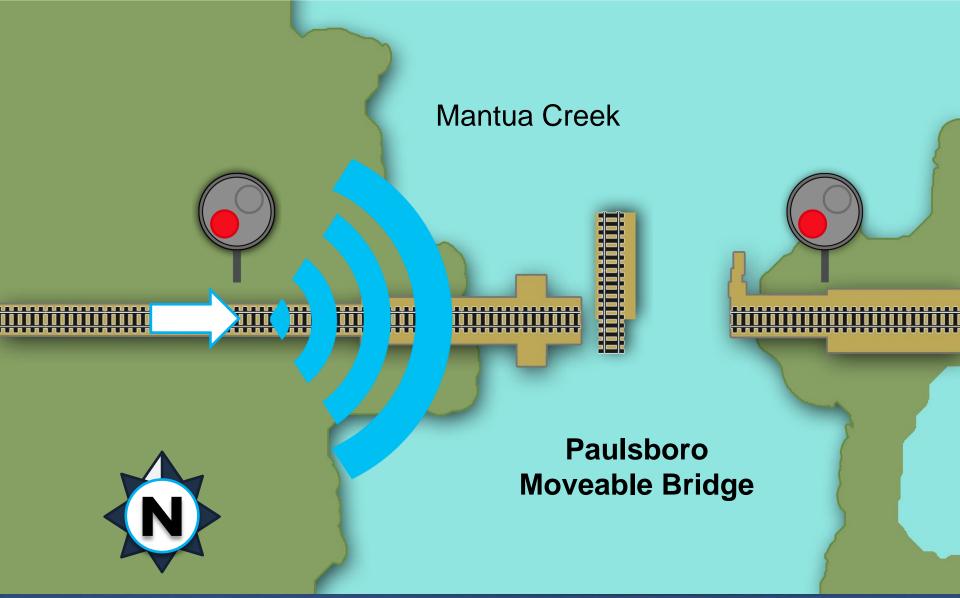


March 2 - December 1



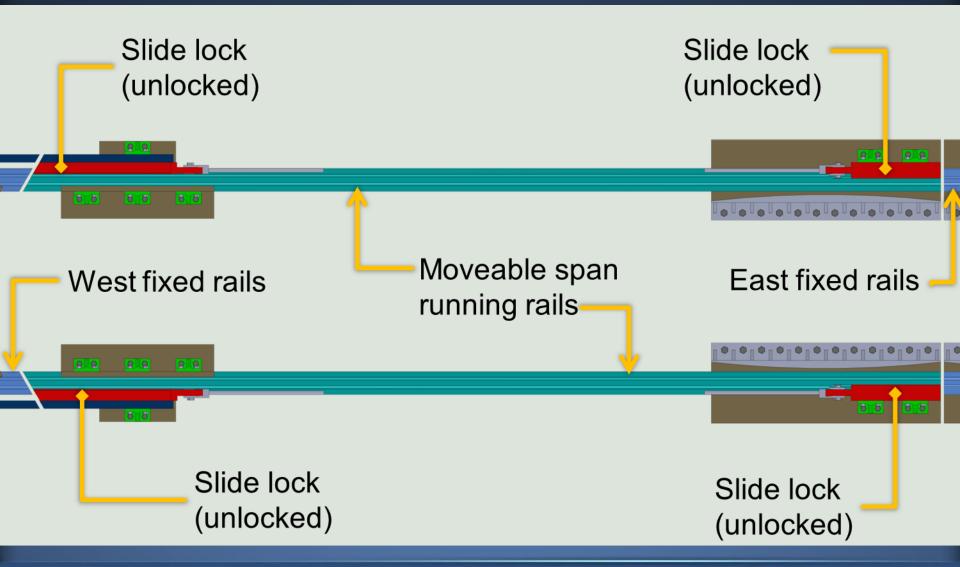


March 2 - December 1



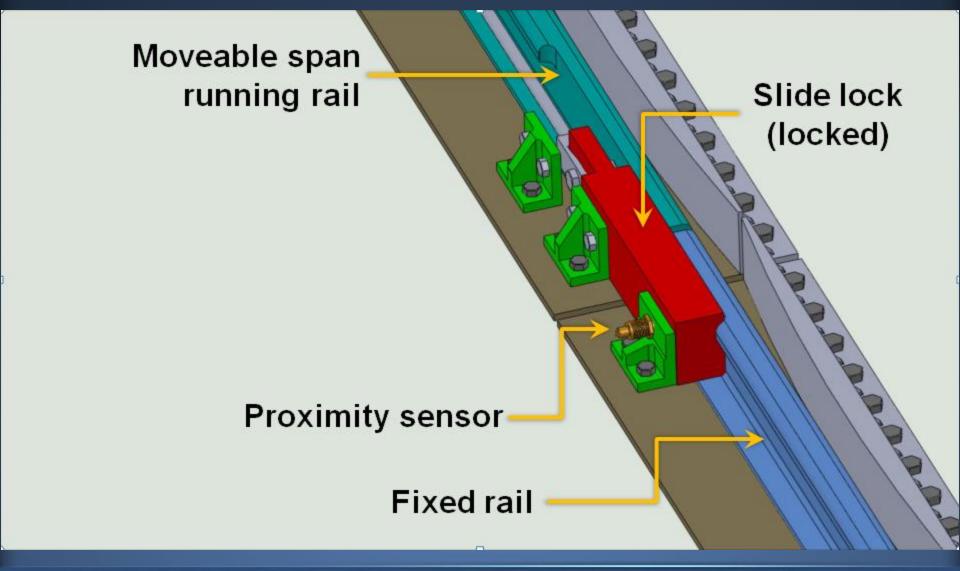


Slide Lock Operation



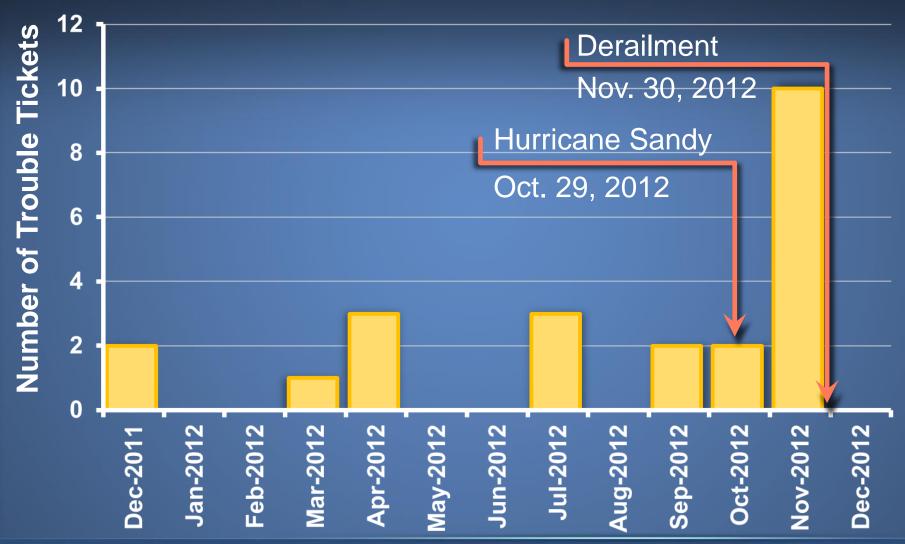


Slide Lock Operation

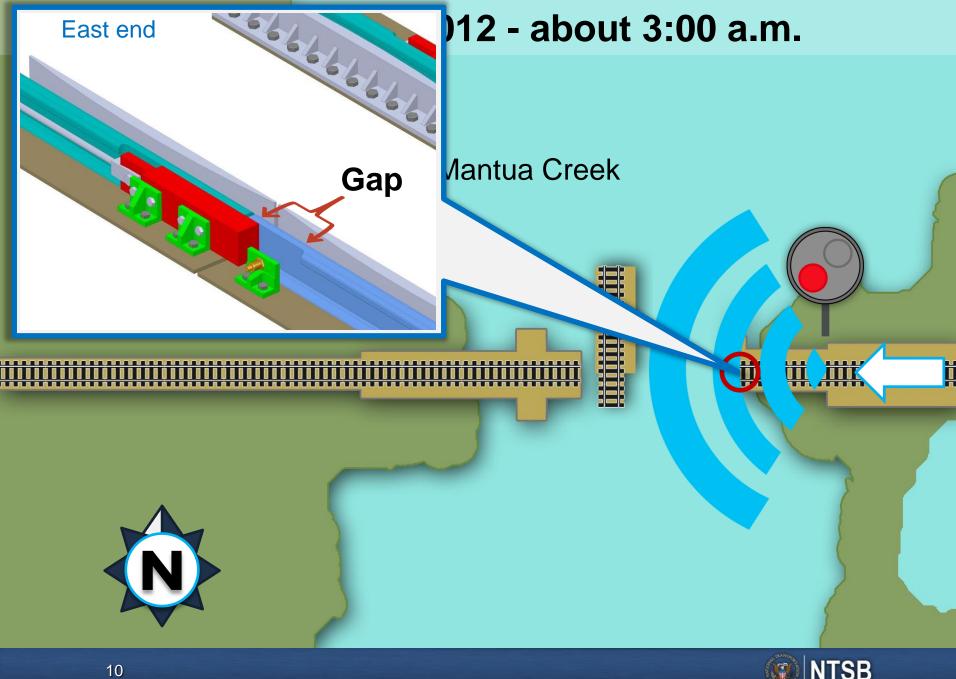


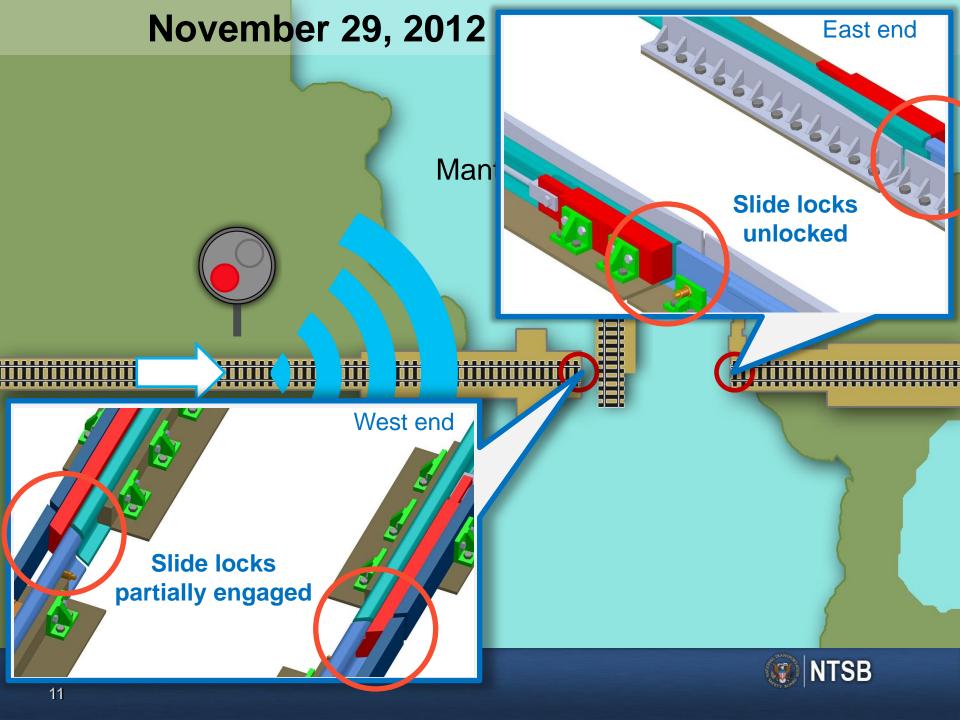


Bridge Operation Problems

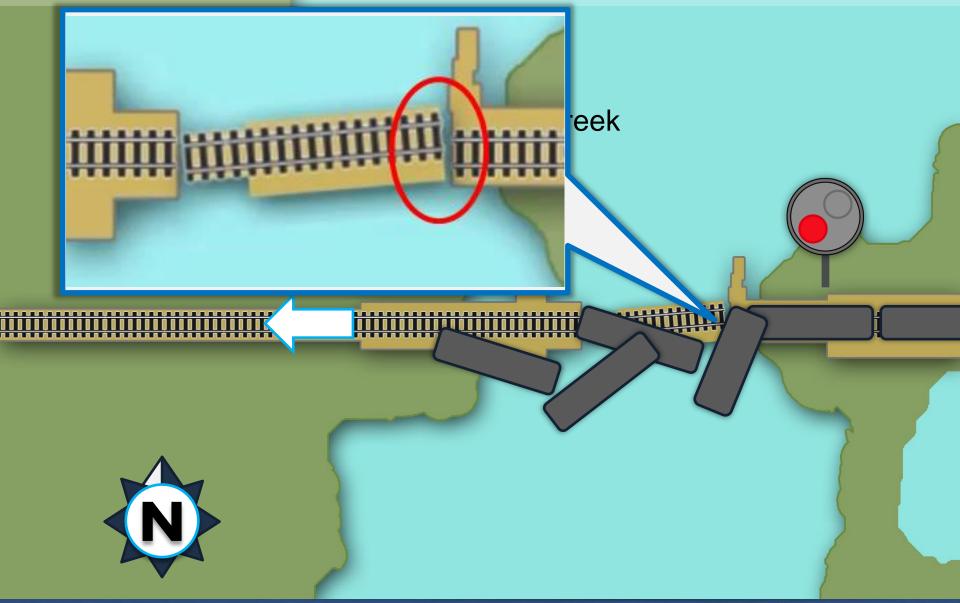








November 30, 2012 - 6:52 a.m.



November 30, 2012 - 7:02 a.m.





Punctured Tank Car



Emergency Response

- Initial notification
- First responders staged in "hot zone"
- No respiratory protection used
- Unified command established after 6 hours



Investigative Hearing July 9-10, 2013

- Conrail bridge operations
- Initial emergency response
- Hazardous materials incident management
- State and federal emergency response actions



Safety Issues

- Qualification of bridge inspectors
- Conrail safety management
- Hazardous materials communications
- Hazardous materials response protocols
- Firefighter training and qualifications
- Emergency planning and preparedness
- Rail corridor risk management



Proposed Safety Recommendations

- U.S. Department of Transportation
- Federal Railroad Administration
- Consolidated Rail Corporation
- Association of American Railroads
- American Short Line and Regional Railroad Association
- International Association of Fire Chiefs
- National Volunteer Fire Council
- New Jersey State Agencies



Reiterated Recommendations

Federal Railroad Administration

Pipeline and Hazardous Materials
 Safety Administration



Investigation Team

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Tim DePaepe

Rick Downs

Muhamed El-Zoghbi

Joe Epperson

Gena Evans

Cy Gura

Investigator-in-Charge

On-scene IIC

Signals

Emergency Response

Hazardous Materials and Emergency Response

Materials Laboratory

Editor

Track and Structures



Investigation Team - continued

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Matt Nicholson

Mike Richards

Ted Turpin

Dave Watson

Electrical Engineering

Human Performance

Recorders

Materials Laboratory

Investigative Hearing Officer

Meteorology

Operations

Mechanical



Staff

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- Kelly Nantel
- Alice Park
- Ruben Payan
- Carl Schultheisz
- Joe Scott
- Eric Stolzenberg
- Christy Spangler
- Jane Terry
- John Vorderbrueggen
- Terry Williams



Parties to the Investigation

- Consolidated Rail Corporation (Conrail)
- Federal Railroad Administration
- Brotherhood of Locomotive Engineers and Trainmen
- International Association of Sheet Metal, Air, Rail, and Transportation Workers
- TrinityRail
- State of New Jersey





Conrail Operating Issues

Ted Turpin

Safety Issue

Training and qualification of train crews for moveable bridge inspection



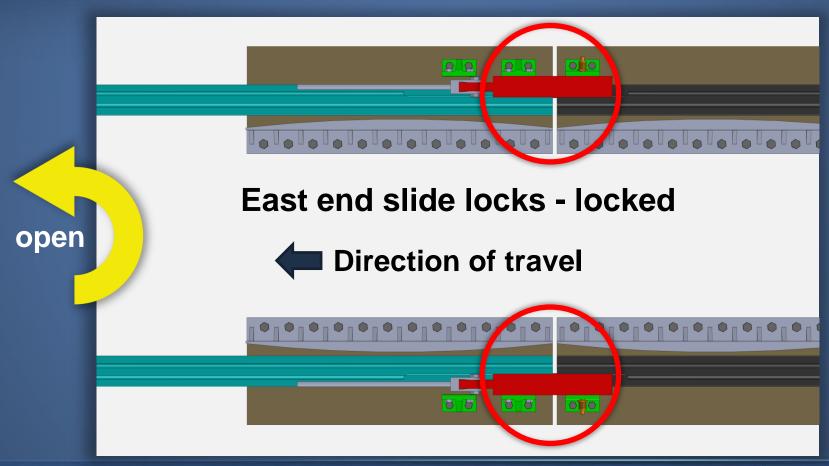
Conductor's Training

- Inspected with an experienced conductor four years earlier
- No formal training
- Had not inspected a bridge until accident
- Uncertain when slide locks were fully engaged
- Answers did not demonstrate knowledge



Physical Evidence on Bridge

No damage to components in circled areas





Physical Evidence on Train





Bridge Not Locked

- Inadequate training
- Uncertain answers
- No damage to slide locks
- Strike marks on wheels
- Erroneously determined locked



Conrail Training

- No specific instructions for inspecting moveable bridges
- No posters or other job aids
- Other crewmembers had no formal training
- Manager confirmed no formal instructions



Conrail Training

- No written instructions in training program
- Training comes from on-the-job
- Inspecting bridge random



Conrail Training

- Conrail did not ensure inspections by qualified employees
- Unstructured on-the-job training
- Did not prepare crews



Conrail Postaccident Actions

- No permission to pass stop signals
- Crews notify dispatcher
- Dispatcher informs trouble desk
- Notify maintenance department
- No longer rely on operating crews



FRA Safety Advisory

- Evaluate the design of moveable bridges
- Evaluate operating rules for stop signals
- Review the adequacy of all training
- Encouraged railroads to take corrective action



FRA Safety Advisory

- Operating employees could be qualified
- Qualified employee was not defined
- No specific training was described
- FRA does not track implementation
- FRA does not enforce



Existing Regulation for Passing over a Broken Rail (49 CFR 213.7(d))

- Minimum experience
- Requires training with examinations
- Periodic requalification
- Establishes specific subjects
- Requires watching and be prepared to stop the train
- Enforceable by FRA





Hazardous Materials Emergency Response

Muhamed El-Zoghbi

Issue Areas

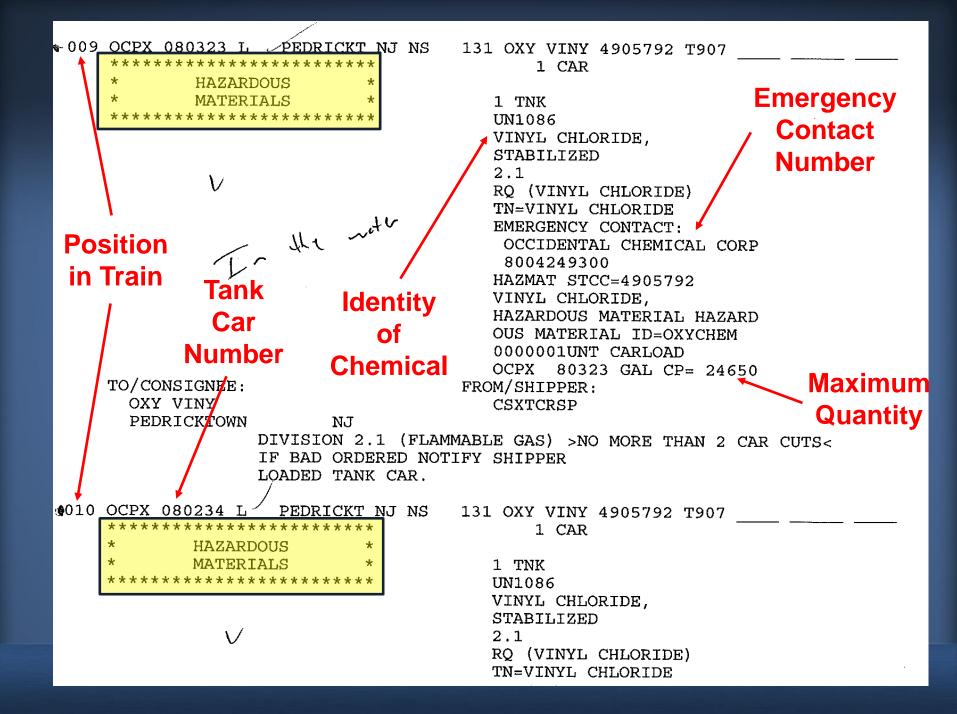
- Hazardous Materials Communications
- Emergency Response Protocols
- Community Protective Action Measures
- Community Awareness Programs and Emergency Response Planning
- Oversight of Emergency Operations Plans
- Hazardous Materials Routing and Risk Analysis



Hazardous Materials Communications

- Responders need train consists to identify, locate, and secure hazardous materials
- Train consist <u>not</u> immediately available to responders at all times
- Conrail retained possession for 3.5 hours





Hazardous Materials Communications

- Instructions to crews may be contributing to delays in emergency information
- Railroad emergency response information inconsistent with and not as protective as Emergency Response Guidebook



Hazardous Waste Operations and Emergency Response (HAZWOPER)

- Emergency responders knew uncontrolled hazardous materials release occurred
- OSHA HAZWOPER standard, 29 CFR 1910.120, requires:
 - Site assessment
 - Appropriate emergency operations
 - Personal protective equipment









Initial Command Post location



Hazardous Waste Operations and Emergency Response (HAZWOPER)

- Responders exposed to vinyl chloride
- Other local and state agencies failed to comply with HAZWOPER standard
- Citations for violations were issued



Community Protective Action Measures

- Initial evacuation and shelter-in-place decisions based on erroneous reports
 - Liquefied petroleum gas vs. vinyl chloride
 - Vapor cloud reported "nontoxic"
- Inadequate measures to correct errors and misinformation

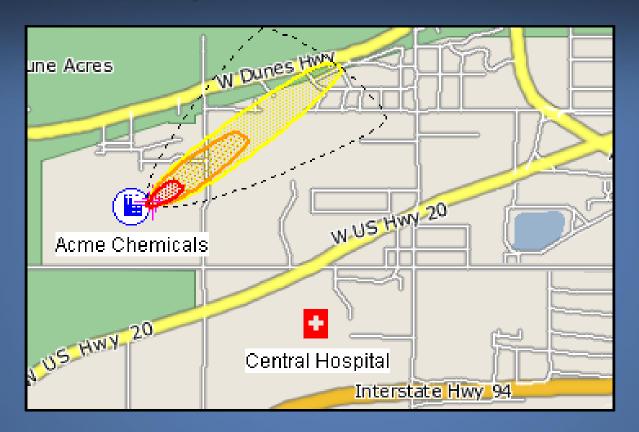


Community Protective Action Measures

- Fact-based decisions regarding community exposure did not occur
- Estimate endangered area and potential harm to community
- Determine concentrations of released hazardous material within area



Example ALOHA Model



Red, orange, and yellow zones indicate where specific level of concern thresholds exceeded



Community Awareness Programs and Emergency Response Planning

- Responders and community unfamiliar with hazardous materials routinely transported through Paulsboro
- Railroad community awareness is voluntary
- Communities unprepared for hazardous materials transiting their neighborhoods



Community Awareness Programs and Emergency Response Planning

 Fixed facility threshold planning quantities often lower than quantities transported by rail

Chlorine

Fixed facility: 100 lbs (a cylinder) - Planning required

- Rail: tank car (180,000 lbs) – No planning required



180,000 lbs





Oversight of Emergency Operations Plans (EOP)

- Emergency Operations Plans:
 - Assign responsibility and set lines of authority
 - Describe how people will be protected
 - Identify resources for response
- In New Jersey EOP recertification every 4 years
- Paulsboro EOP was 2 years past due recertification



Oversight of Emergency Operations Plans (EOP)

- State relies on counties to conduct reviews
- No audits or procedures to verify capabilities
- Many municipalities are non-compliant
- Inadequate accountability for non-compliance



Routing and Risk Analysis

- Rail Corridor Risk Management System (RCRMS) software is inadequate for shortline railroads
- RCRMS does not assess risk when alternate routes are unavailable
- Conrail aware of shortcomings and failed to conduct thorough risk assessment





| National Transportation Safety Board